AN AUTOETHNOGRAPHIC ACCOUNT OF MINDFULNESS-BASED STRESS REDUCTION AS A TREATMENT APPROACH FOR EATING DISORDERS

by

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BSW, University of Victoria, 2015

MAJOR PAPER SUBMITTED
IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

In the School of Social Work and Human Services

UNIVERSITY OF THE FRASER VALLEY

Spring 2018

Approval

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Degree: **Master of Social Work**
Title: **An Autoethnographic Account of Mindfulness-Based Stress Reduction as a Treatment Approach for Eating Disorders**

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Abstract

Eating disorders and disordered eating are known to be difficult to treat. The Mindfulness-Based Stress Reduction (MBSR) program pioneered by Dr. Jon Kabat-Zinn has shown much promise in the treatment of various ailments, including decreasing emotional eating in the general population. Using autoethnography as my methodology, this research centres on my experience in the MBSR program in which I seek to determine if MBSR will help decrease emotional and dysfunctional eating in a former bulimic.

Acknowledgements

I would like to thank Dr. Zoë Sehn for her suggestion and encouragement to explore autoethnography as my research methodology. Thank you for reminding me why our stories are so important. I would also like to thank Dr. Katherine Watson for her incredible and unwavering support of my foray into the autoethnography world and her determination to help me succeed. A huge thank you also to Dr. Leah Douglas and Dr. Lisa Moy for their honest, kind, supportive and constructive feedback that helped solidify my research paper to what it is today. I could not have done this without all of you.

Introduction

As a social work student, I have always been interested in exploring the conceptualization and treatment of eating disorders in our field. This is probably because, for more than half of my life, I was bulimic. And while I would consider myself recovered, there are still aspects of the disorder that were left untreated. Although I have given up dieting, and on the surface, the need to be thin, I still have a troubled relationship with food. Food is a crutch that I lean on when life gets hard. And food is still the enemy, a constant temptation with which I am always at war. There is a very real struggle at the heart of wanting food for comfort and dealing with the shame of succumbing to these temptations at the expense of having a skinny body. Giving up bulimia meant giving up having 'the best of both worlds'. At least that is what it has meant for me.

Although there were aspects of formal treatment programs, such as cognitive behavioural therapy, that assisted in my recovery, these did not address some of the underlying issues. Given that eating disorders are generally known to be difficult to treat (Fassino & Abbate-Daga, 2013), perhaps the helping professions, and those of us who struggle with this battle, need to be looking at other non-conventional treatment avenues.

I have known for years since my recovery that my troubled relationship with food still needed to be examined, addressed and repaired. Through my explorations of self-help literature, I came to believe that the answer lies in mindfulness.

I first became interested in mindful eating through *Women, Food and God*, a self-help book by Geneen Roth (2011). In it, she details her experience of overcoming emotional eating by reconnecting with her body and becoming mindful of its hunger and satiety cues. I have managed to, on a few glorious occasions, put her suggestions into practice and experience the incredible feeling of eating for nourishment only. These glimpses taught me that I can indeed

have a satisfying relationship with food. But I have yet to put these few experiences into permanent practice.

I began to explore mindfulness further and came across the Mindfulness-Based Stress Reduction (MBSR) Program developed by Dr. Jon Kabat-Zinn. It is an eight-week mindfulness program originally designed for those living with chronic pain (Kabat-Zinn, 2005). The program involves daily meditation and mindfulness practices and watching videos and reading articles related to mindfulness. Kabat-Zinn (2005) describes mindfulness as the "disciplined practice of moment-to-moment awareness" (p. 11). By cultivating mindfulness, we can learn to enter deep states of relaxation (Kabat-Zinn, 2005). Kabat-Zinn (2005) believes that relaxation provides us with greater clarity so that we can see the way we actually live and make changes to improve our quality of life.

Although I have yet to see any research of this particular program applied as a treatment intervention for eating disorders, I wanted to see if it was helpful to decrease emotional and dysfunctional eating by bringing awareness and consciousness to the process of selecting and eating foods. To explore and test this, and using autoethnography as my methodology, this research centres on my experience in an eight-week mindfulness-based stress reduction program. Through this I attempt to determine the answer to the following question: will MBSR help decrease emotional and dysfunctional eating?

Literature Review

Eating Disorders

Eating disorders involve an excessive intake or strict avoidance of food (Godsey, 2013). There are eight categories of eating disorders listed in the DSM-5. They are anorexia nervosa, bulimia nervosa, binge eating disorder, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder, and unspecified feeding and eating disorders (American Psychiatric Association, 2013). Anorexia nervosa is characterized as maintaining a body weight of less than 85 percent of what is expected, combined with an intense fear of fat and a significantly distorted body image (Garfinkel, 2002). Bulimia nervosa involves the same fear of fat but leads to binge eating and resulting compensatory behaviours including self-induced vomiting, laxative abuse or over-exercising (Garfinkel, 2002).

The most commonly diagnosed eating disorder is eating disorders not otherwise specified (ter Huurne et al., 2015). This diagnosis is made when an individual does not meet all of the criteria set out in the DSM-5, but many of the indicators are present (American Psychiatric Association, 2013). Sadly, subthreshold disordered eating behaviours (those that do not meet full diagnostic criteria) are highly prevalent (Bush, Rossy, Mintz & Schopp, 2014).

Nine out of ten individuals diagnosed with anorexia nervosa and bulimia nervosa are females (Scott, Hanstock & Patterson-Kane, 2013). Women in Western countries where there is a strong idealization of thinness are more likely to be affected (Scott et al., 2013). According to the Centre for Excellence in Eating Disorders (2005), compared with the general population, women with eating disorders are 32 times more likely to commit suicide (as cited in Weber, Davis & McPhie, 2006). The National Institute of Mental Health (2012) reports that the

mortality rate of anorexia nervosa is 12 times the death rate of all causes of death for females aged 15 to 24 combined (as cited in Godsey, 2013).

Eating disorders are known to be difficult to treat and carry high relapse rates (Aspen, Darcy & Lock, 2014). Research has shown that ten years after treatment, only 10 percent to 11 percent of patients with bulimia nervosa and anorexia nervosa were symptom-free (Von Holle et al., 2008, as cited in Scott et al., 2013). One explanation for the difficulty of treating eating disorders is the fear these individuals carry of gaining weight (Aspen et al., 2014). This results in an avoidance, or disengagement from treatment (Aspen et al., 2014). Dropout rates are high for those in outpatient treatment: up to 70 percent (Fassino, Piero, Tomba & Abbate-Daga, 2009). An explanation for this may be located in the incongruencies between patient and practitioner expectations (Swain-Campbell, Surgenor & Snell, 2001). While therapists focus on eliminating disordered eating behaviours, many people with eating disorders remain unconvinced of the need to change and value their symptomology (Swain-Campbell et al., 2001).

Another explanation for the difficulty of treatment is that eating disorders become a coping mechanism that help those affected deal with difficult experiences and emotions (Cockell, Zaitsoff & Geller, 2004). Personal barriers can prevent clients from seeking out treatment as well, such as feelings of shame or fear of stigmatization (ter Huurne et al., 2015). Cost and lack of available treatments also present barriers to individuals seeking help (ter Huurne et al., 2015).

A frequently recommended approach of treatment for both anorexia nervosa and bulimia nervosa is cognitive behavioural therapy (Hay et al., 2014). Cognitive behavioural therapy addresses the relationship between what we think, how we feel and how we behave (Somers, 2007). This therapy involves challenging disordered behaviours, cognitions and patterns of

thinking that maintain the disorder (Hay et al., 2014). The goal is to identify dysfunctional thoughts and replace them with healthier thoughts which will lead to feeling differently and ultimately behaving differently (Somers, 2007). Cognitive behavioural therapy is the most documented approach for eating disorder treatment (Scott et al., 2013).

A meta-analysis conducted by the UK National Institute for Health and Clinical Excellence, along with a systematic review by Shapiro et al. (2007) and Hay et al. (2009) found that cognitive behavioural therapy is the leading treatment for bulimia nervosa (as cited in Murphy, Straebler, Cooper & Fairburn, 2010). Wilson and Fairburn (2007) reported that for bulimia nervosa, cognitive behavioural therapy was more effective than antidepressants, non-specific psychotherapy and behaviour therapy (as cited in Scott et al., 2013). For individuals with bulimia nervosa and binge-eating disorder, cognitive behavioural therapy has been found to be the most effective long-term treatment in binge/purge behaviour reductions and psychological features associated with bulimia nervosa (Groff, 2015).

Less research has been conducted in regard to cognitive behavioural therapy and anorexia nervosa (Murphy et al., 2010). The evidence is inconclusive as to whether this treatment is superior than others. Having said that, for bulimia nervosa, Wilson and Fairburn (2007) found that only 40 percent of patients had ceased bingeing and purging twelve months post-treatment with interpersonal therapy and cognitive behavioural therapy (as cited in Scott et al., 2013).

Specialist supportive clinical management, the Maudsley model of anorexia nervosa treatment for adults (a manualized individual therapy), motivation-based therapies, interpersonal psychotherapy, cognitive analytic therapy and focal psychoanalytic therapies all may be helpful approaches in treating anorexia (Hay et al., 2014). Group psychoeducation has also been reported to improve outcomes for some patients if combined with interventions such as cognitive

behavioural therapy (Davis, McVey, Heinmaa, Rockert & Kennedy, 1999). Nutritional counselling is also considered a useful therapy when used in conjunction with another form of therapy (Reiter & Graves, 2010).

While there is no clear indication that any specific form of treatment is superior to another, what is clear is that meaningful engagement in therapy and techniques to enhance change are crucial components of treatment (Hay et al., 2014). A meta-analysis spanning a 20 year period (1977-1997) found that the strength of the alliance between practitioner and patient was associated with symptom improvement, independent of patient and treatment factors (Martin, Garske, & Davis, 2000).

While pharmacological treatment for anorexia is an option, there is weak evidence to support its effectiveness (Hay et al., 2014). There is small, but weak evidence supporting the use of interpersonal psychotherapy and dialectical behaviour therapy in both bulimia nervosa and binge eating disorder (Hay et al., 2014). There is also evidence to support the effectiveness of using antidepressants to treat both bulimia nervosa and binge eating disorder (Hay et al., 2014). What is clear is that mainstream treatment practices are not entirely effective. This is where I believe mindfulness has a role to play in the treatment of eating disorders.

Mindfulness

According to Godsey (2013) mindfulness involves paying attention to the present moment and the unfolding of the moment by moment experience. It is described as paying attention in a particular way, non-judgmentally (Bush et al., 2014). It involves distancing the self from thoughts, emotions and behaviours (Godsey, 2013). Bishop et al. (2004) describe mindfulness as self-regulation of attention on immediate experience that facilitates increased recognition of mental events in the present moment (as cited in Hick & Furlotte, 2009).

Mindfulness cultivates self-awareness, self-compassion and healthy physical practices including healthy eating, exercise, adequate rest and hydration (Cook-Cottone, 2012). Shapiro, Carlson, Astin and Freedman (2006) have posited four mechanisms of mindfulness and these include self-regulation, values clarification, exposure to thoughts and emotions and cognitive, emotional and behavioural flexibility (as cited in Bush et al., 2014). Grossman, Niemann, Schmidt and Walach (2004) found three decades of research showing that mindfulness-based stress reduction improves physical and psychological health (as cited in Bush et al., 2014).

Mindfulness is at the heart of Buddhist meditation but does not require an affiliation with any religion as its practices are universal (Kabat-Zinn, 2005). Mindfulness needs to be learned and practiced and becomes more effective the more that it is practiced (Kabat-Zinn, 2005). Key elements of mindfulness include awareness and a nonjudgmental attitude of acceptance toward the moment-to-moment experience (Hayes & Feldman, 2004). These elements are considered effective antidotes against psychological distress (Hayes & Feldman, 2004).

Mindfulness does not change our emotions, but it does change our relationship to our emotions (Ellison, 2006). Mindful awareness allows us to see fluctuations in mood moment to moment so we can navigate around them (Ellison, 2006). For example, if a person feels anger rising, a mindful approach would encourage us to sit with the emotion and feel it in the body (Hick & Furlotte, 2009). Rather than push away the anger, we would explore and experience it and consequently we begin to understand it deeper and become better able to respond with clarity (Hick & Furlotte, 2009).

Mindfulness practices include meditation, which focuses on breath work, intuitive eating and yoga. A common approach is to focus on the sensations of breathing or an object, notice

every inhale and exhale and when you notice your mind wander, gently return your attention back to your breath (Ellison, 2006).

Mindfulness and Social Work.

Buddhist mindfulness training aims to alleviate human suffering which is highly compatible with social work's objective to enhance well-being (Turner, 2008). In a social work context, mindfulness refers to a treatment model, a mode of self-care or a tool to enhance the client-worker relationships (Hick & Furlotte, 2009). Clients can benefit from both having a mindful clinician and learning mindfulness skills to reduce distress (Turner, 2008). The present moment orientation of mindfulness has been found to provide benefits at the individual, group and community levels in social work, including developing increased attention, increased self-awareness, fostering empathy and compassion, inner peace and calm and more insight leading to ways of living and being that are transformative (Caholic, 2005; Berceli & Napoli, 2006; Minor & Carlson, 2006; Hick, 2009, as cited in Lynn & Mensinga, 2015).

Mindfulness and Eating Disorders.

In eating disorders, food is used to regulate emotional experiences (Corstophine, 2006, as cited in Godsey, 2013). Food is also used to block out awareness of emotions (Corstophine, 2006, as cited in Godsey, 2013). Intuitive eating is a mindfulness-based practice that helps people learn how to eat in response to actual, physical hunger cues (Bush et al., 2014). Those with eating disorders tend to rely on external cues to eat, versus internal cues (Bush et al., 2014). Intuitive eating rejects dieting and instead relies on hunger and satiety cues, redeveloping an intuitive relationship with the body and with food (Bush et al., 2014). Because, for example, binge eating is an attempt to regulate emotion, bringing nonjudgmental awareness to emotions

may be beneficial in helping decrease this behavior (Bush et al., 2014). Awareness may open the door to new information that supports healthier eating practices (Bush et al., 2014).

Although research on mindfulness practices as a treatment intervention for eating disorders is fairly limited, the results available show promise. Mindfulness-based treatments have been found to produce positive outcomes in relation to bulimia nervosa, anorexia nervosa and binge eating disorders (Wanden-Berghe, Sanz-Valero & Wanden-Berghe, 2011). A study by Hepworth (2011) reported that mindful eating provided long-term improvements in individuals diagnosed with eating disorders (as cited in Godsey, 2013). Lavander, Jardin and Anderson (2009) found that they were less likely to find disordered eating behaviours in those who had higher levels of mindfulness (as cited in Wanden-Berghe et al., 2011). Prowse, Bore and Dyer (2013) reported that participants who acted with awareness (meaning they focused their mind on the present) were less likely to present with eating disorder symptoms. Another study by Masuda, Price and Latzman (2012) found that college students scoring high in mindfulness were less likely to engage in disordered eating behaviours. Levoy, Lazaridou, Brewer and Fulwiler (2017) reported that participants selected from the general population experienced a decrease in emotional eating after working through the MBSR program. Daubenmier et al. (2011) found that mindfulness techniques reduced anxiety, responsiveness to bodily sensations and emotional eating (as cited in Godsey, 2013).

Mindfulness has also been reported to have a significant impact on one's relationship with food. Alberts, Thewissen and Raes (2012) found that non-clinical participants who engaged in disordered eating experienced a decrease in food cravings and emotional eating after participating in a MBCT-eating intervention. Mason et al. (2016) found that mindful eating was associated with decreased consumption of sweets and lower fasting glucose levels. Ruffault et

al. (2016) reported that mindfulness training decreased impulsive eating. Arch et al. (2016) found that brief mindfulness increased participants' enjoyment of food and also resulted in lower calorie consumption of unhealthy foods. A study by Hendrickson and Rasmussen (2017) reported that mindful eating reduced impulsive food selection and Jordan, Wang, Donatoni and Meier (2014) found that mindfulness encourages healthier eating, including a decrease in caloric consumption and healthier food selection.

A study by Atkinson and Wade (2016) reported that significant effects were achieved through the utilization of mindfulness. These effects included reductions in the thin ideal internalization, dietary restraint, psychosocial impairment and eating disorder symptoms (Atkinson & Wade, 2016). Leahey, Crowther and Irwin (2008) found that combining emotional regulation and distress tolerance skills with mindfulness-based interventions was effective in managing urges to binge eat (as cited in Wanden-Berghe et al., 2011).

Tylka (2006) reported that higher levels of intuitive eating were associated with less disordered eating, less pressure to be thin and less body dissatisfaction (as cited in Bush et al., 2014). Bush et al. (2014) found that combining intuitive eating with mindfulness practices resulted in an increase of body appreciation among female participants, as well as a decrease in problematic eating behaviours.

However, Atkinson and Wade (2016) report that the counterintuitive and metacognitive nature of mindfulness techniques may make it less accessible for some people, and consequently less attractive as a treatment option. Mindfulness also requires consistent practice over time for optimal benefit (Atkinson & Wade, 2016).

Theoretical Framework

There are several theories that I draw from in my autoethnography. These include mindfulness, narrative therapy and feminist perspectives.

Mindfulness

Theories that centre on a mind-body connection posit that mental and physical health are connected. From a mind-body perspective, the way we feel, think and behave can significantly affect our physical health, for better or for worse (Kabat-Zinn, 2005). But the roots of mindfulness go much deeper and further back in time. Mindfulness and the mind-body connection has its roots in Buddhist meditation practices and perspectives (Williams & Kabat-Zinn, 2011). The roots of mindfulness go back to the teachings of the Buddha who lived and taught in fifth century BC (Bodhi, 2011). The Buddha's teaching, the Dharma, was a set of principles and practices that guided humans in their quest for happiness and spiritual freedom (Bodhi, 2011). At the heart of the Dharma is insight that leads to overcoming suffering (Bodhi, 2011). Resting at the core of Buddhist tradition is the ancient knowledge that understanding how the mind and body construct experience can be used to attain greater health and happiness (Olendzki, 2011).

The first Noble Truth of Buddha is that there is suffering (Teasdale & Chaskalson, 2011a). However, although unpleasant and uncomfortable feelings are unavoidable, suffering is optional (Teasdale & Chaskalson, 2011a). The message of this principle is that our present moment experiences are not the problem; the problem is when we need to have our experience be a particular way (Teasdale & Chaskalson, 2011a). Our need to get rid of unpleasant feelings or sensations is what creates suffering (Teasdale & Chaskalson, 2011a).

When we are attached to a particular outcome or are resistant to what is happening around or inside us, mindfulness offers us a pathway through these conditions in which suffering arises, thus ending our suffering (Teasdale & Chaskalson, 2011b). The concept of mindfulness is that we quiet the mind and disengage from its tendencies to perceive our experiences in terms of what we like and dislike (Dreyfus, 2011). By paying attention to the present moment, we disengage from the automatization of our habitual judgmental tendencies (Dreyfus, 2011). By focusing on our current experience and noticing our reactions, we learn to develop a state of non-reactive equanimity that allows us to see things as they are rather than from a state of reactivity (Dreyfus, 2011). The goal is to use our non-reactive state to free our mind from tendencies that lead to suffering (Dreyfus, 2011).

One of the benefits of mindfulness is that it often leads to a reduction in distress following upsetting events (Teasdale & Chaskalson, 2011b). Through the practice of mindfulness, we will start noticing that experiences that may have previously been upsetting for hours, may now only lead to a disturbance for a few minutes or even only a few seconds (Teasdale & Chaskalson, 2011b). An explanation for how this works is that we can reduce suffering by intentionally redirecting the focus of our attention to bodily sensations that are relatively neutral and that are less likely to sustain emotion-laden thoughts (Teasdale & Chaskalson, 2011b). By focusing on bodily sensations and observing thoughts in the moment, we start to de-identify with the experience personally (Teasdale & Chaskalson, 2011b). The practice of mindfulness teaches us to maintain focus on the sensations in the body, including the movements of the breath, and to recognize when the mind has wandered away and to bring the attention back to the body or the breath (Teasdale & Chaskalson, 2011b). This practice cultivates the skills of recognizing when the mind is lost in thought and then intentionally

redirecting its focus so as to disengage from thought patterns that might create emotional suffering (Teasdale & Chaskalson, 2011b).

When we become lost in our thoughts and the chatter of the brain, our mind begins to manipulate concepts related to the experience which strays us from the direct experience itself (Teasdale & Chaskalson, 2011b). Rather than focus on ruminating thoughts about distressing events, we focus on awareness of thoughts, feelings and sensations instead which brings us back to the present moment (Teasdale & Chaskalson, 2011b). Mindfulness cultivates within us a willingness to allows things to be just as they are (Teasdale & Chaskalson, 2011b). A mindful response to a distressing event involves letting the experiences of the moment, all the unpleasant thoughts, feelings and sensations, be there, just as they are, as we hold them in our awareness (Teasdale & Chaskalson, 2011b).

Behavioural medicine was the first discipline to integrate mindfulness into its applications (Williams & Kabat-Zinn, 2011). This integration began with the Mindfulness-Based Stress Reduction Program developed by Dr. Jon Kabat-Zinn in 1979 (Williams & Kabat-Zinn, 2011). The foundation of the program is that often we are barely present in our own lives and our own bodies as they are experiencing and unfolding and consequently we have not cultivated the inner resources available that might benefit us, such as awareness (Kabat-Zinn, 2011). The intention behind MBSR was to recontextualize the Buddha's dharma into frameworks of science, medicine and healthcare so that it would be useful for those who had not discovered its benefits through the traditional dharma (Kabat-Zinn, 2011).

MBSR is about healing and accepting things as they are, in full awareness (Kabat-Zinn, 2011). If mindfulness is not our default mode, then we are likely functioning from a state of mindlessness and unawareness (Kabat-Zinn, 2011). This causes us to get caught up in moments

from a reactive, automatic and robotic perspective that can potentially colour our life and our relationships (Kabat-Zinn, 2011).

A major focus of the MBSR program is the practice of relating more skillfully to unpleasant feelings to avoid suffering (Teasdale & Chaskalson, 2011a). In order to build these skills, we have to have the courage to move into the suffering, to let it be present and investigate how we create and sustain it (Teasdale & Chaskalson, 2011a). Through mindfulness and focus, we learn to calm down enough to sit in moments of well-being and relaxation that both nourishes and restores the body and mind (Kabat-Zinn, 2005).

Narrative Therapy

The second theoretical framework utilized in my autoethnography is narrative therapy. Narrative therapy, developed by White and Epston, has its roots in the postmodernist work of Michel Foucault (Lock, Epston & Maisel, 2005). Narrative therapy does not focus on whether or not a problem is present in a person's life, but rather, what sense a person makes of their problems (Lock et al., 2005). People's lives are made up of experiences that they organize in ways that make sense to them (Abels & Abels, 2001). These events are stories, or narratives that are given meanings and create the "landscape of the person's life" (Abels & Abels, 2001, p.1). We all have stories about ourselves, our abilities, our competencies, our relationships, our work, our achievements and our failures (Morgan, 2000). These stories are developed by how we have linked specific events together and by the meaning we have attached to them (Morgan, 2000). Our stories are also influenced by larger stories of the cultures in which we live (Morgan, 2000).

Author Geneen Roth (2011) introduces the concept of stories that we carry about ourselves in her book *Women, Food and God*. She explains that just because we believe something about ourselves, does not mean it is true (Roth, 2011). We internalize stories about

ourselves based on our experiences and feedback from those around us, but we can challenge and change these stories (Roth, 2011).

Narrative practice assumes that individuals' self-views and behaviours are shaped by stories about themselves (Burner, 1990, as cited in Abels & Abels, 2001). In some cases, the stories people hold about themselves may be harmful, but through the process of re-authoring, these stories can be deconstructed and reconstructed into a new story, or narrative that reflects a preferred way of life (White, 1991, as cited in Abels & Abels, 2001).

Applied to work with eating disorders, narrative therapy explores the meanings clients have constructed regarding the influence of their eating disorders, as well as the factors that support or undermine that influence (Weber et al., 2006). Narrative therapy does not consider eating disorders in terms of deficit, inadequacy or disordered personality, but rather recognizes that it is situated in a context of meaning-making (Weber et al., 2006). The goal of narrative therapy is to replace the dominant story that is maintaining the eating disorder's hold and replace it with an alternative story based on values and desires that have been hidden by the eating disorder (Scott et al., 2013).

Externalizing an eating disorder allows for an inquiry into the new relationship with the problem (Lock et al., 2005). Externalization involves creating a separation between the person and the problem (Weber et al., 2006). This approach allows a shift towards examining the relationship the person has with the problem (Lock et al., 2005). Externalizing can also help clients deconstruct some of the "truths" they have about their lives (Weber et al., 2006). By separating the person from their eating disorder, the person's understanding of their eating disorder can be brought into the open to be inspected and challenged (Lock et al., 2005).

Another avenue to explore takes the focus away from eating and reconnects clients with the things they value (Scott et al., 2013). Moving the focus away from eating also allows for an exploration of issues that led to the development of the eating disorder (Scott et al., 2013).

The evidence in support of narrative therapy in the treatment of eating disorders is limited. Most evidence is limited to informal case studies (Scott et al., 2013). Case studies by Epston (1999), Maisel et al. (2004) and Nylund (2002) all found that narrative therapy helped clients change their attitudes towards their eating disorder as well as increasing their resistance to its influence (as cited in Scott et al., 2013). Weber et al. (2006) found that narrative therapy in a group setting reduced eating disorder risk. Lainson (2016) reported that through her use of narrative practices, her clients reported feeling less like something was wrong with them.

As Michael White explains, narrative therapy stands outside of the territory defined by psychiatric knowledge and pathologizing discourses (Lock et al., 2005). Because it is based on post-modern ideas about looking outside of the medical model, it makes sense that empirical evidence relied on heavily by science and medicine, is few and far between.

As Hepworth et al. (2010) point out, there is a danger in clinical practice of inflating the role of therapist as social scientist who utilizes a reasoned method comparable to a mathematical equation (as cited in Marsten, Epston & Johnson, no date). Marsten et al. (no date) explain that knowledge claims are questionable as they are always approaching expiration dates, at which time they are then replaced by a new current fashion with the same claim to universal truth. Rather than relying on what science knows, narrative therapy investigates and privileges the knowledge the individual holds (Lock et al., 2005).

Feminist Frameworks

Because autoethnography involves examining the connection between the person and the culture (Ellis & Bochner, 2003) I draw from feminist frameworks to analyze the cultural conditions that contribute to the development of eating disorders in western societies.

Eating disorders are quite firmly entrenched within the medical model and as such, they are pathologized as an individual failing, with social and cultural influences relegated to the periphery in treatment (Holmes, 2016). But like many problems that become pathologized in our society, once you peel back the layers you begin to see that there are much larger influences in society operating to create and maintain these 'problems'.

Feminist approaches recognize that disordered eating problems are gendered and they advocate for a nonpathologizing and socially contextualized approach to eating disorders (Brown, Weber & Ali, 2008). Feminist critiques have drawn attention to the fact that medical perspectives reject or resist frameworks that challenge their power (Holmes, 2016).

I will explore feminist arguments that dismantle cultural and social constructions of gender and the resulting expectations placed upon women's bodies and social roles (Holmes, 2016). I will explore thinness as the current standard of beauty that is being equated with living a disciplined lifestyle (Dyrenforth, Wooley, & Wooley, 1980, as cited in Brown et al., 2008). In applying a feminist lens, we begin to see that disordered eating needs to be contextualized within a food culture that glamorizes and sells skinny (Schott, 2015). Eating disorders also need to be located within the context of fat shaming in our society (Brown-Bowers, Ward & Cormier, 2017).

Design and Methodology

MBSR Program

My research involved putting myself through the eight-week MBSR program and journaling about my experience. My hope was that by moving into the resistance to address the lingering troubles I have with food, I would begin to heal this relationship and provide insight into the process of how this can be achieved for others suffering from any kind of emotional or dysfunctional eating.

Through the use of personal narrative, a form of autoethnography (Ellis, Adams & Bochner, 2011), I documented my journey through the eight-week MBSR program. The program I followed was a self-guided program by Dave Potter, a fully certified Mindfulness-Based Stress Reduction instructor. This is an eight-week program modelled after the MBSR program developed by Dr. Jon Kabat-Zinn of the University of Massachusetts Medical School. This program has been uploaded to Potter's website https://palousemindfulness.com/.

This website provides material and instructions for each week of the mindfulness journey. The materials include weekly readings, videos, formal and informal practices and daily meditations. Every day for eight weeks I committed to the program's daily practices of meditation and mindfulness. To document this process, I journaled about my experience of moving into the resistance and bringing mindfulness to areas of my life I have wanted to ignore until now. I focused on how this process was impacting my relationship and struggle with food.

I was drawn to the MBSR program because of the success Jon Kabat-Zinn (2005) has seen in his stress reduction clinic at the University of Massachusetts Medical School, which I learned about through reading his book *Full Catastrophe Living*. In this book, he talks about the

application of the MBSR program to many ailments, so I was curious to see if this could be applied to disordered eating as well.

Autoethnography

In order to capture my internal experiences of working my way through the MBSR program, I chose autoethnography as my research methodology. Autoethnography involves "systematic sociological introspection and emotion recall to try to understand an experience" (Ellis & Bochner, 2003, p. 206). It is an "autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural" (Ellis & Bochner, 2003, p. 209). Autoethnography involves rigorous self-questioning and the willingness to confront things about yourself that may not be very flattering (Ellis & Bochner, 2003). The goal of autoethnography is to invite readers into the researcher's world and feel the events that are being described and use what they learn to broaden their understanding and coping in terms of their own lives (Ellis & Bochner, 2003). Autoethnographers move back and forth between experiencing and examining aspects of their lives (McIlveen, 2008, as cited in Mendez, 2013).

Personal accounts are important because they offer new and unique knowledge that can be applied to a broader audience (Wall, 2006). These stories can offer readers information about unfamiliar people and unfamiliar lives (Ellis, 2004, as cited in Bartlett, 2014). Autoethnographic research is tested by readers as they determine whether or not a story speaks to them in terms of their own experiences or the experiences of others they know (Ellis & Bochner, 2000).

Autoethnography can enrich our understanding of the world, expand our awareness and provide insight that leads to action (Witkin, 2014). It is a valuable form of inquiry because it allows readers to become aware of realities they have not considered before (Mendez, 2013).

Data Analysis

In terms of data, I have 42 pages of computer journal entries. I used two processes of analysis in the study. I analyzed my narrative by thinking *with* my story and thinking *about* my story (Frank, 1995, as cited in Bartlett, 2014). Thinking *with* a story involves experiencing it as it is affecting your life and discovering truths about your life (Ellis, 2004, as cited in Bartlett, 2014). While I was engaged in the MBSR program, I journaled about my experiences and reflected on what the process was like integrating mindfulness into my life, how I was feeling, what progress I was making, where I was struggling, where I needed more work and overall how my journey through mindfulness was impacting my life and my relationship with food. This involved continual reflection on my experiences and daily journaling to capture my thoughts and feelings. This form of storytelling invites both reader and author to reflect on their life stories (Irvin, 2003). This required great vulnerability on my part to reveal myself (Ellis & Bochner, 2003).

In thinking *about* a story, I looked to identify common themes and patterns (Bartlett, 2014). I reviewed and reflected on my journal entries to identify any insights that were not captured while I was thinking *with* my story. I drew on existing research and theories and connected them to emerging themes and my personal experiences (Ellis, 2004, as cited in Bartlett, 2014).

I have found that stories have had the most impact on me in terms of applicability to my own life. Stories teach me about life and how to do it better. My aim was to provide an alternative method and account that speaks to the emotional journey one takes through a healing process and a process of self-discovery in our relationship with food.

Ethical Considerations

To conduct this research, I did not need approval from the University of the Fraser Valley's Ethics Board. The reason for this is that I am the subject of my research which is considered minimal risk. I was, however, aware that in writing an autoethnography there were three main ethical considerations involving the reader, the individuals I wrote about, and myself as the writer. In terms of considerations for the reader, eating disorders can be an emotionally charged topic. For the readers for whom this topic hits close to home, they may experience unpleasant feelings in response to what they are reading and these responses cannot be predicted (Bochner & Ellis, 1996, as cited in Mendez, 2013). However, I have written about my experiences in a carefully considered way, ensuring that I kept the reader, my audience, in mind at all times.

Autoethnography also involves describing experiences of a researcher's life that involve sensitive issues for the researcher and the people around her (Wall, 2008, as cited in Mendez, 2013). As such, I have not identified anyone by name in my project, but rather only identified those by their relationship to me. Anyone who was referenced in my work was advised about this project and their inclusion in it and all were given an opportunity to request their exclusion from it. Although there are no definitive rules around this (Ellis, 2007) anyone who I included in my writings was able to review my account and their feedback was carefully considered and weighted before I submitted my final product. Ultimately, autoethnography is an ethical practice itself that entails being honest about the events that have transpired and of the words expressed by those involved in the events (Ellis, 2007).

Finally, I needed to ensure safety for myself delving into my eating disorder history and facing my troubled relationship with food. Chatham-Carpenter (2010) provides an

autoethnographic account of trying to write an autoethnography about her recovery from anorexia and how facing the experiences from her past triggered old impulses to lose weight and become thin. She realized she was not as recovered as she thought (Chatham-Carpenter, 2010). I needed to ensure that I maintained awareness of my emotional experiences throughout this project and sought support when needed. Fortunately for me, this research did not result in a resurgence of old eating disorder impulses.

Findings

In thinking about my story, I was able to identify several common themes and patterns, as suggested by Bartlett (2014). I reviewed my journal and also reflected on my experience through the program as a whole. There were several key themes that emerged from my research that mindfulness was able to shine a light on. The first was the understanding that I am still using food to cope with emotions. The second was that I continue to experience resistance to dealing with and facing my relationship with food and that unintentional mindfulness is not enough. The final emerging theme was that I am still attached to the ultimate goal of losing weight.

Emotion Regulation

The first theme that has emerged from my research was around emotion regulation. I have always known that I have had difficulties with my emotions. But I also thought that I had made progress. After my recovery, I started to feel very good about my life. I felt strong and like I could handle anything life threw at me. And I did: I ended a long-term relationship, moved out on my own for the first time, dealt with my mom going through cancer, and changed jobs multiple times. But I also was not challenged the way I am being challenged now. I have been in a very difficult relationship for almost two years. It has brought up a lot of emotion within me that I am struggling to cope with. And through mindfulness, I started to recognize that I have been turning back to food for solace, comfort and escape. The emotional strength I thought I possessed has been waning.

On day 2, I wrote:

So I am constantly wound up, upset, worried, angry. I am in a constant state of fluctuating emotions. It's both draining and exhausting… I want to stuff my face and stuff my emotions down.

On day 7, I wrote:

I am still unable to tolerate distressful feelings and emotions. I want to run and hide from them. I want to run and hide from anything that causes discomfort. But I'm realizing more and more lately that that isn't the way.

On day 16, I wrote:

So perhaps I'm trying to eat to cover up these feelings. Again, I don't stop to pay attention enough to know.

On day 22, I wrote:

…I left feeling angry and frustrated. I had a bag of popcorn in the car. And even though I wasn't really hungry, I began to eat. That mindless hand to mouth eating, like you do in a movie theatre with popcorn. Except this time I was driving. When I finally tuned in to what I was doing, I realized that I had eaten more than half the bag.

Theoretical and empirical literature point towards an association between eating disorders and problems with emotion regulation (Pisetsky, Haynos, Lavender, Crow & Peterson, 2017). In eating disorders, food is used to regulate emotional experiences (Corstophine, 2006, as cited in Godsey, 2013). Food is also used to block out awareness of emotions (Corstophine, 2006, as cited in Godsey, 2013). It is clear that I am still engaging in both of these practices. I have begun to realize that my inability to regulate my emotions effectively without using food is interfering with any progress I could potentially be making with mindful eating.

Having said that, mindfulness also claims to help with emotion regulation. Because, for example, binge eating is an attempt to regulate emotion, bringing nonjudgmental awareness to emotions may be beneficial in helping decrease this behavior (Bush et al., 2014). Awareness may open the door to new information that supports healthier eating practices (Bush et al., 2014).

Research has also found that mindfulness meditation decreases binge eating and emotional eating in individuals engaging in this behavior (Katterman, Kleinman, Hood, Nackers & Corsica, 2014).

According to Richard Davidson of the University of Wisconsin at Madison, meditators start to learn to de-identify with their emotions, which makes it easier to let them go (as cited in Ellison, 2006). I suppose they do not call this meditation practice for no reason. It is a practice because it takes time to learn and become effective.

Becoming Aware

As my foray into mindfulness progressed, I did start to notice a shift.

On day 31, I wrote:

This evening my boyfriend got mad at me again. I started packing up my things, wanting to escape his wrath. But then I stopped myself. I really didn't want to leave him. Rather than storm off and try and escape something I didn't want to face, I stopped myself, faced my boyfriend, and he responded in kind. I think that mindfulness certainly helped me stop from escalating myself with emotions.

On day 44, I wrote:

I sat at my laptop this morning and felt like a failure. My relationship with food is still shit. My research has failed. I'm worse off than in a long time. What have I learned? What can I share? How have I been brave? And then it hit me. My journey really hasn't been about someone finding their way with food. It's been about navigating my relationship with a very challenging man. Mindfulness has forced me to really see what's happening to me and my life. It's made me ask myself some tough questions. It's made me realize how hard this all is on me. It's made me see how I've changed. How angry I've become. And yet the whole point of meditation is

something entirely different. Or the results of it are supposed to be. Yet how can you be zen when you're fighting with your partner all the time? How can you focus on your relationship with food when your anger is getting out of control? When you're mad at your partner constantly?

On day 49, I wrote:

What mindfulness has done though, is allow me to become more aware of what's happening in my internal world. I might be freaking out still emotionally, but I'm aware of what I'm doing. This awareness hasn't necessarily resulted in any changes yet, but awareness is the first step.

On my last day, day 54, I wrote:

I had a thought today. I caught a glimpse of myself in a mirror in a store. And I was devastated. I looked horrible. I've gained weight and I look horrible. All I could focus on after when I was walking out of the store was how thick my thighs were and how they smushed together. What a terrible feeling. But as I was walking out of the store, I paused. And I asked myself what would happen if I showed myself kindness and compassion right now. What would happen? Because I was craving chocolate. I had been all morning. I just wanted to stuff my face with chocolate. But I asked myself if chocolate was what I truly wanted. I wasn't sure.

I ended up going to buy myself some actual lunch and a tea. And yes, I did stop to buy myself some chocolate. But what was interesting is that I stopped the self-flagellation. I've been through a lot. I'm still going through a lot. And I'm surviving. And while I cope to get through, I told myself that it was okay to have gained weight. It was okay. I was going to be okay. And rather than spend the rest of the day feeling horrible about myself, I didn't.

It's interesting how a moment can change your outlook. How a shift in thought can change the way you see yourself… I really took care of myself today. And I feel good right now for it.

Although mindfulness did not prove to be the cure-all I had hoped for, it brought awareness into my life. This awareness then provided me with opportunities to make different decisions about how I would handle my emotions or how I would interpret the events around me. Reviewing my journal again, I have started to see that I made more progress than I thought I did. I assumed that the indication of success would be a thin body, but I am starting to see that assumption was incorrect.

Avoidance of my Relationship with Food

The second theme that emerged was my continued avoidance of addressing my troubled relationship with food. I suppose I knew there was resistance on my part to exploring this. But I did not realize quite how much. I also thought that simply by engaging in mindfulness I would naturally become aware of my relationship with food and make changes. Although I have become much more aware of what I am doing, how I am existing in the world, how I am feeling, what emotions I am experiencing, I am also more aware of the continued resistance.

On day 1, I wrote:

Today, I woke up and that same resistance that has been following me around for years was present. No. I don't want to meditate. I don't want to become mindful. Because I don't want my blanket taken from me…my comfort. I don't want to lose food.

On day 7, I wrote:

I was aware that I was craving chocolate. I felt that need and that urge. And I stopped for a moment and realized that these were the moments I needed to pay attention to. If I ever want to repair my relationship with food, these are the moments that I need to move into… And as quickly as these thoughts came, I cast them aside.

On day 13, I wrote:

And I just don't want to apply this to my relationship with food yet. I really really don't. I just don't want to give this up. I don't want to take away my blanket, my crutch, my focus, my comfort.

On day 16, I wrote:

I also buy two Reese eggs and a pack of Hershey's mini eggs. I come back to the office, start drinking lots of juice and eat everything I bought except for one egg. I'm pretty sure I'm not hungry, but I don't stop long enough to pay attention.

On day 33, I wrote:

I still feel incredibly frustrated that I haven't lost any weight. I haven't engaged in mindful eating. I'm still avoiding dealing with this. I feel like a failure. I feel like I'm letting myself down. But this isn't happening organically through the process of incorporating mindfulness into my life. Perhaps I need to bring a more conscious effort to eating. I just don't really want to.

On day 49, I wrote:

It seems like it's been very difficult to be mindful lately. It's like I'm checked out. After I finished my semester of school I was done. I didn't want to work. I didn't want to pay attention. Even meditating has become a chore. Another item on the to-do list.

My findings and experiences are not unique, particularly as it relates to disordered eating. Resistance to treatment is common and provides an explanation for why eating disorder treatments often fail (Aspen et al., 2014). Some aspects of resistance to treatment can be automatic and unconscious while others are generated consciously to actively oppose treatment (Fassino & Abbate-Daga, 2013). Research has shown that a common conflict experienced by

individuals with bulimia is the desire to stop binge eating and a resistance to give up restrictive eating patterns that lead to binge eating (Aspen et al., 2014). In binge eating disorder, high levels of emotional eating predict resistance to treatment (Halmi, 2013).

What is also interesting is that mindfulness literature speaks to resistance as well. Dr. Jon Kabat-Zinn (2005) explains that people tend to experience resistance of the mind and body to settle into things as they are. This resistance can become compounded if we are meditating for change, to make things different and to improve our lives (Kabat-Zinn, 2005).

Upon reflection, I observed that, like most things, mindfulness does not operate within a silo. I reflected that bringing mindfulness to my life again has been good. But it has not provided the radical shift in thought, perception and experience that I had hoped it would. When I began compiling this data, and started to analyze the themes, I felt defeated. I was still struggling. I was not eating mindfully. My research felt like it was failing. However, I concluded that perhaps I needed to trust in the process of mindfulness. Perhaps I needed to practice one of Dr. Jon Kabat-Zinn's (2005) pillars of mindfulness: that of non-striving. In his companion book to the MBSR program, Kabat-Zinn (2005) says that in order to achieve your goals you need to back off from striving for results. Instead, you need to focus on being present and accepting things as they are, moment by moment (Kabat-Zinn, 2005).

Mindful Awareness and Eating

But these things do not happen overnight. And although I still struggled with resistance through my entire research process, I did notice a shift. I started to have moments where, through mindful awareness, I was able to move into the resistance and discomfort.

On day 27, I wrote:

I walked to Shopper's Drug Mart…and I saw some mini-eggs that were calling out to me. But then I listened to the voice in my head that just said nah. Or no. I just knew that I didn't want them. My body didn't want them. I was actually craving something not sweet. I was looking around and then I saw cheese. I needed protein. So I bought some sliced cheese and ate it when I got back to the office. THAT is what my body wanted.

And on day 33 I had a breakthrough:

I feel the urge to eat. And I'm stopping myself to discover the why. I want to escape and run free. I feel tired and unfocused. But I think I might try yoga…

So I did the yoga. I do feel better. More calm. Except that sometimes when I'm relaxed or being particularly mindful I just want to cry. It's like it brings out all this emotion in me. And so when I finished yoga, this happened to me. And what did I do? I grabbed the chocolate bar I had in my bag. But right as I took my first bite, I stopped mentally and realized that so often lately I've been getting emotional. And I realized that I was telling myself that this was a bad thing. That I must be so unhappy. I started telling myself a story about my feelings. Rather than just inhabiting the sadness or impulse to cry, I created an entire scenario for what I thought the feelings meant. And then I did something unexpected. I continued to eat the chocolate, but this time, I did it mindfully. I savoured the chocolate. I chewed it. Like really chewed it. Swirled it around in my mouth. And as I was taking my second to last bite I thought, wow, this is really sweet. I could have stopped there. But of course, I had one more bite left. And come on. I haven't made THAT much progress. But I ate the chocolate mindfully. And I have another in my bag. I was going to eat them both. But because I ate the one mindfully and realized that the sweetness wasn't actually what I was going for, I won't be grabbing the second one. I'm

actually hungry. Like I need food. But I don't want another chocolate. So maybe I am making progress. Maybe if I continue to turn towards what I'm feeling, rather than run from it, I will start discovering what's happening in my life. I will start learning the reasons why I turn to food. And I will start to unravel those reasons and actually deal with what's in front of me, rather than continue to try to escape from it and run from it.

On day 35, I wrote:

Today I carried along with my mindful eating. My boyfriend packed me a lunch. And it was amazing. Carrots and his famous mashed potatoes. I added some cheese. And I was in heaven. Normally I sit at my desk and eat and work or read or do something else. Today I sat at my desk and ate, but I focused on eating. I allowed myself to enjoy the experience. I can't remember the last time I fully tasted carrots the way I did today. And the mashed potatoes…combined with cheese. It was a delight. It wasn't even that much food. But it was so incredibly satisfying. A few hours later I got very hungry and so I had the Yorkshire pudding he included. I didn't need it before, but when I was hungry I ate it. It was so great to feel hunger and then feel the satisfaction that food can provide in alleviating hunger.

On day 48, I wrote:

Again, I wasn't that hungry today. I ate bits and pieces here and there. I certainly let myself get hungry. I brought a piece of seafoam to work. Chocolate covered. But I just didn't want it. I actually didn't want it. I was struggling with feeling tired all day. At lunch I went out and bought a steeped tea from Tim Hortons. It did wonders for me. Completely picked me up. And I didn't want to ruin it by making myself tired having chocolate. So I didn't. That's so weird to me. But there you have it.

What I started to learn through this process is that mindfulness is not enough. You cannot just meditate every day and expect your life to change. There has to be a conscious effort. I watched a video by Vidyamala Burchabout called "Turning Toward Difficulty" (2016 February 27). She speaks about how meditation takes care of one hour of the day, but what about the other 23 hours? We have to put into practice what we learn. Mindfulness requires practice. And not just of the formal sitting kind. This actually aligns with some research by Van De Veer, Van Herpen and Van Trijp (2016) who found that mindfulness meditation that focused on the body enhanced participants awareness of hunger and satiety cues, but mindfulness meditation with a different focus did not. Mantzios and Wilson (2014) found that participants who brought present moment awareness to the sensory properties of food experienced a more significant weight loss than the control group (as cited in Tapper, 2017). Beshara, Hutchinson and Wilson (2013) found that mindful eating correlated with consuming small portion sizes at mealtime. So, it really is important that mindfulness be focused on the act of eating itself.

Once again, I thought the benchmark of success was being thin, but I realize that it is not. What started to happen, through bringing mindfulness into my life, is that I became more aware, and that included moments of being aware of my intentions to eat and the process of eating. No, I was not able to sustain this every day, all day. But there were certainly increases in mindful eating. This leads me to my comments regarding the final theme of my research.

Insights

I think that I was in denial about what I really wanted to achieve here. I have stated that I want to change my relationship with food. And although that remains true, my ultimate goal has always been to lose weight. That fear of fat that characterizes eating disorders is still ever present and gnawing at me.

On day 28, I wrote:

I had a realization today. I realized that I am using meditation and this program as a weight loss program. I am striving for a better relationship with food. But really, that is a glossed over way of saying, I want to lose weight.

The following day, I tried to work through these expectations:

I started thinking today about how fat I had become. My clothes are getting tight. It's a pretty shitty feeling. And I started feeling frustrated that meditation isn't working. That mindfulness isn't making me eat less. And then I had to bring myself back. What if weight loss wasn't the goal? What if I chose not to buy into the idea of skinniness as beautiful and the ultimate status symbol? What if I just allowed myself to be exactly as I am? Right here, right now. What if I just allowed myself to be? Perhaps, this is the point of meditation. To bring us home to ourselves.

On day 46, I wrote:

I feel so fat. I feel like a complete failure. My research has failed. I'm getting fatter by the minute. My clothes keep getting tighter. My pictures look worse and worse. I can't deny my fatness anymore.

It is clear that I still connect the size of my body to success or failure. But the goal of my research was not to lose weight. It was to repair my relationship with food and decrease my emotional eating. It has certainly done this, although not in the way I had secretly hoped. I guess I was not being honest with myself about what I had wanted to achieve. No, I am not losing weight. But I am beginning to repair something that needed to be repaired.

Cultural Connection

But why is it that weight loss is still my ultimate goal? I would be remiss here if I did not make some cultural connection in my autoethnography to the cult of thinness surrounding us in western society. I continue to blame myself for my 'failings' yet society sets us up for failure in the first place. In regards to eating disorders and disordered eating, there are other ways to conceptualize this 'problem', other than residing within the individual.

Eating Disorders and Gender.

Eating disorders need to be understood within the context of oppressive gender ideologies and inequalities operating in our western patriarchal society (Malson & Burns, 2009, as cited in Schott, 2015). It is no coincidence that nine out of ten individuals diagnosed with anorexia nervosa and bulimia nervosa are females (Scott et al., 2013). Feminist analysis frames the problem of eating disorders within the social and cultural constructions of gender and expectations around the female body, appetite, sexuality and social roles (Holmes, 2016). Eating disorders can be seen as a cultural statement of the conditions of being a woman and expressing a diverse range of societal values that map out normative parameters of what it means to be feminine (Malson, 2009, as cited in Holmes, 2016). Individualizing eating disorders keeps the cultural ideologies related to female bodies, appetite and desire hidden (Holmes, 2016).

Not surprisingly, women in western countries where there is a strong idealization of thinness are more likely to be affected by eating disorders (Scott et al., 2013). Feminist views acknowledge that the internalization of the thin body ideal can be implicated in the development of body and eating distress, however, they caution that eating disorders should not be reduced to individual body image problems (Malson, 2009 as cited in Holmes, 2016). We need to look deeper than that.

In Western society, being thin is the current standard of beauty which is equated with leading a disciplined lifestyle (Dyrenforth, Wooley, & Wooley, 1980, as cited in Brown et al., 2008). Feminist research shows how prescriptions of femininity play out through discourses of discipline and containment (Holmes, 2016). This gendered expectation of self-restraint is enacted by women through dieting and weight control (Brown et al., 2008). Self-esteem and individual value are associated with self-restraint, self-denial and self-control (Brown et al., 2008). Ironically, these traits are also associated with eating disorders (Gremillion, 2003, as cited in Brown et al., 2008). Anorexia, therefore, can be seen as an extreme form of self-restraint, discipline and self-control.

What is interesting is that even within feminist work, the study of anorexia has been privileged over bulimia, creating a hierarchy in which anorexia is the morally superior illness (Squire, 2003, as cited in Holmes, 2016). Because bulimics tend to have a normal body weight, their bodies provide a less visual representation of the struggle of femininity (Holmes, 2016).

Eating Disorders and Neoliberalism.

Applying a critical lens, we need to consider who is benefiting from the problem of eating disorders and who is harmed by it (Baines, 2011). What we find is that eating disorders are "culturally-induced diseases promoted partly by economic and social institutions that profit from "the cult of thinness" promoted by mass media" (Hesse-Biber et al., 2006, as cited in Schott, 2015, p. 5). It turns out that businesses and institutions actually profit off of the sale of thinness. Neoliberal government practices prioritize expanding opportunities for business and corporations to increase their profits (Baines, 2011). This reflects the heart of neoliberalism. Business and economic interests are succeeding at the cost of women and their bodies.

Bordo (1993) points out that we live in a bulimic culture: one that encourages mass consumption but also the restriction of excess and temptation (as cited in Brown et al., 2008). Ten multinational corporations control half of the food supply in the world (Goodall, 2006 as cited in Schott, 2015). As such, corporate giants can dominate grocery shelves and mass marketing (Winson, 2012, as cited in Schott, 2015). Marion Nestle (2002) reports that 70 percent of the 33 billion spent on promotional campaigns by food companies is spent on convenience foods, candy, snacks, alcohol, soft drinks and desserts with only 2.2 percent on vegetables, fruits, grains or beans (as cited in Schott, 2015). So even though women are bombarded with messages about thinness as the ideal, we are also, at the same time, bombarded with marketing campaigns that are trying to sell us unhealthy food that will most likely contribute to weight gain. When healthy eating is communicated to us as an individual responsibility, it obscures the involvement of food companies and allows them, and our government, to remain unaccountable (Schott, 2015).

Fat Shaming.

Medical discourse contributes to fat shaming within our society. Within a medical context, being fat represents unhealthiness and disease, whereas thinness represents good health (Brown-Bowers et al., 2017). The establishment of the body mass index has resulted in the production of fatness as a medical condition (Jutel 2006, 2009, as cited in Brown-Bowers et al., 2017). Weight loss and dieting are the first remedies medical practitioners turn to in order to target the problem of fatness (Brown-Bowers et al., 2017).

Anti-fat biases within psychology can be found in psychological literature in which fat is presented as a problem to be treated (McHugh & Kasardo, 2012 as cited in Brown-Bowers et al., 2017). In a manual for treatment of binge eating disorder, treatment efficacy is equated with

weight loss (Brown-Bowers et al., 2017). Fatness is also identified as a central target for treatment (Brown-Bowers et al., 2017). Food restriction is a frequently recommended treatment option (Brown-Bowers et al., 2017). Ironically, these very goals are shared by individuals who are anorexic and whose bodies have been identified as needing intervention to restore them to good health.

Through research, long-term weight loss has been found to be virtually impossible for the majority of individuals (Bacon & Aphramor, 2011 as cited in Brown-Bowers et al., 2017). In fact, research has shown that there are actually greater harms associated with being underweight than being overweight (Campos et al., 2006, as cited in Brown-Bowers et al., 2017) such as an unhealthy preoccupation with food and body, cyclical weight loss and weight gain, distraction from improving other health determinants, lower self-esteem, and the development of eating disorders (Bacon and Aphramor, 2011; Olson et al., 2000; Patton et al., 1999, as cited in Brown-Bowers et al., 2017).

Research has also shown that health can be achieved through many different shapes and sizes (Lelwica, Hoglund & McNallie, 2009 as cited in Schott, 2015). This implies that facts about fat appear to be immune to scrutiny (Tischner, 2013 as cited in Brown-Bowers et al., 2017). Why? Because fat does not measure up to our current beauty standard of thinness. It is clear that the medical profession has been swayed by skinny discourse as well, given the contrary research that is available but ignored. This may be yet another reason why treatment for eating disorders has been found to be so ineffective. The medical profession is ignoring the fact that diets do not work and have actually been proven to be bad for one's health. And because they have the power to define 'problems' and their treatment, interventions remain targeted in the wrong areas.

Women who struggle with eating disorders are but "[t]he bearers of very distressing tidings about our culture" (Bordo, 1993, p. 60, as cited in Brown et al., 2008). Perhaps the point of intervention needs to be located within the culture, and not the individual.

Final Reflections

I started this process back in March and now I sit here in September after having read my journal. It is interesting what perspective can do. I had told myself that the marker of my success would be weight loss. The program only worked if I lost weight. But that is not the marker of success. The marker of success was leaning into the resistance of my relationship with food. Learning to eat mindfully. Eating mindfully. What I saw is that this started to happen. There was a shift. Reading my journal I could see it. It took hold for a few weeks. And then a life-changing moment occurred with my relationship and it bulldozed me off the path of mindful eating. I do not want to get too distracted or caught up in the details of this moment, but what I can say is that I had a profoundly painful realization about my relationship. Although this moment sidetracked my commitment to mindful eating, what my mindfulness and meditation practice allowed me to do was look through the emotional tangle I was caught in. And I could finally name the experiences I had been going through that had been tormenting me. Although I am disappointed that this derailed my journey, I am also grateful that it provided me with the clarity I needed.

What is interesting is that after my research finished I wanted nothing to do with meditation and mindfulness. I left it all completely behind. I did not want to have to face my life anymore. I wanted to hide from it and just pretend that everything was okay. But life has a funny way of working out. The relationship problems that I did not want to face, that plagued me through my whole journey of the MBSR program have now come to a head - in a very

painful way. But what is interesting is that this time I have no desire to eat or stuff my face. Because this time, I am actually dealing with the problem. Reading my journal now I see how much I needed help back then. I understand how much the relationship sidetracked my life and how my eating was just a way to try and get through the days because I was afraid of facing what was in front of me. But I can see now, that when you actually choose to deal with what is in front of you, there is no need to stuff your face.

I have observed that, when I pay attention to food and eat mindfully, I enjoy the experience so much that I stop caring about my weight and my body. I just enjoy what is in front of me without fear of what it will do to me. Paying attention to the joy of food is much nicer than paying attention to how tight my clothes have become or how my thighs are rubbing together.

What mindfulness has done for me, and continues to do for me, is bring awareness into my life. It is my choice whether or not I want to pay attention to it. But that is the simple gift of being present. I still believe that if I commit myself to mindful eating, that eventually it will bring me to where I want to be. But it takes effort and practice and that does not happen overnight. And apparently, for me it did not happen over an eight-week program. At least, not in the way I had hoped for. But the lessons learned are lessons that I can carry with me until I am ready. In my experience, sometimes we need to carry this information with us until the time is right to put them into practice.

Limitations of the Study

The central limitation of my research is my chosen methodology. Autoethnography, like other forms of qualitative research, has received much criticism. Because the research is limited to the analysis of personal narrative, limited conclusions can be drawn from the findings

(Mendez, 2013). The strongest criticism against autoethnography as a research methodology is its focus on the self, which has resulted in resistance to it being accepted as a valuable research method (Mendez, 2013). This methodology has been criticized for being self-indulgent, narcissistic and individualized (Atkinson, 1997; Coffey, 1999, as cited in Mendez, 2013). Another limitation is that the reader's interpretation of the research is subjective, which clashes with positivist research's aim of presenting an objective account of the truth (Mendez, 2013).

Criticism has also been levelled at the reality that personal narratives represent (Mendez, 2013). Walford (2004) explains that people can write fiction, they just cannot call it research (as cited in Mendez, 2013). Walford also questions how much of the accounts in autoethnographies are based on real conversations and how much are inventions of the authors (as cited in Mendez, 2013). I tried to address this limitation by documenting my daily experiences in a journal. That way I was able to capture what happened, as it happened. And although I am reflecting on what has passed, it has not passed that long ago that my memory should be distorted and my account of it inaccurate.

Autoethnography has also been accused of being therapeutic, as opposed to analytic (Mendez, 2013). In my case, I would wholeheartedly agree. I used this process to try and heal an aspect of myself. However, I am opening this process up to others to witness my experiences so that perhaps they may relate to something or learn something that may be helpful in their own lives.

Autoethnography also has no specific rules or criteria (Mendez, 2013), which runs extremely contrary to quantitative methods. However, I have researched autoethnography as a methodology and have captured recommendations for how I should progress through this narrative and what considerations I needed to keep in mind.

Conclusions

Based on my findings and research, I would suggest that mindfulness as a skill be taught to individuals with eating disorders, given the many positive benefits that have been found. Assisting with emotion regulation, an increase in enjoyment of food, a decrease in food consumption and a decrease in binge eating are but a few of the many positive side effects of mindfulness. I can honestly say I have experienced all of these things and more. Through this program, I learned to stop and pay attention to moments in my life that previously would have passed me by. I enjoy the sun on my face or listening to the rain or hearing my boyfriend's full belly laugh or savouring chocolate. As a former bulimic, I know how impossible it seems at times to find any enjoyment in life. Sometimes the hole you are caught in feels so large and deep and gaping. Mindfulness practices may provide some light for those with eating disorders. Even if they continue to struggle with their relationship with food, perhaps they can experience moments of joy in life. Mindfulness can help with this.

Having gone through the MBSR program, I would suggest that this program be part of a two-pronged approach. I think that mindfulness practices and techniques can offer individuals with eating disorders the tools to slow down and start paying attention to what they are doing. I think after going through the MBSR program, perhaps what may be helpful is a more focused mindful eating program. The skills learned through MBSR are broad and do not necessarily have to be applied to eating. I tried to avoid this as much as possible. I was happy to notice my feelings or emotions or how I felt looking out at the ocean or to sit in silence and watch my thoughts, but I avoided eating mindfully a lot. Probably as much as I could.

In terms of further research, I would be interested to see what impact a mindful eating program would have on those struggling with eating disorders, or with its after effects. Perhaps a

program that is more focused would encourage that constant attunement to the eating process and daily practice.

Implications for Social Work Practice

This account will provide helping professionals with insight into the internal experiences of those who engage in disordered eating. Social workers are the largest group of mental health service providers (SAMHSA, as cited in Karger & Hernandez, 2004). In 1998, there were over 190,000 professional social workers, which was more than psychiatrists, psychologists and psychiatric nurses combined (NASW Fact Sheet, 2003 as cited in Karger & Hernandez, 2004). As such, the eating disorder population is one that can be directly impacted by social workers. Given the high relapse rates, it is clear that mainstream treatment is not highly effective. My hope is that the Mindfulness-Based Stress Reduction Program may provide an alternative treatment option for individuals with eating disorders.

Linking personal experiences of eating disorders to larger problems within society, such as gender inequality, privileged medical discourse, neoliberalism and fat shaming, is also important to social work. If social work continues to align itself with the medical profession and remains focused on the pathology of the individual, social work drifts away from its position as the vanguard of social justice (McDonald, Harris & Wintersteen, 2003 cited in Karger & Hernandez, 2004).

Feminist analysis, such as those explored above, need to be brought into treatment. I did not intuitively know that there were forces operating within society beyond my awareness. I had to be shown through education. Women with eating disorders need to become aware of the cultural influences that have helped shape the definition, development and maintenance of their eating disorder.

I still do not know the best way to unlearn socially constructed cultural expectations, but I do know that it is essential to the recovery of women with eating disorders. When you peel back the layers, eating disorders do not appear to be a medicalized problem situated within an individual. Rather they represent a reasonable response to the pressure women experience to be thin in this society, at all cost.

I also hope that my account gives comfort to anyone finding themselves in a similar situation to know they are not alone and that those of us who struggle, struggle alongside one another. In my own experience, learning about similar struggles that others face through their stories provided me with hope that a brighter future was possible. I now know this to be true. I want to share my findings with those who are interested, or who could benefit from, experiencing my journey alongside me.

The goal of my autoethnography is also to give hope to others finding themselves grappling with similar struggles. When I first read Geneen Roth's (2011) book about mindful eating, I began to experience hope that I could break free from this dark relationship I had with food. Her books are similar to an autoethnography. She details her struggles and her experiences and what led her to mindful eating and how it changed her life. She invites the reader to witness these events, and the events and struggles and revelations of some of the women she works with. Her account gave me hope. I want others to know that there is hope out there too.

In my personal experience, I respond more to narratives of those who have been there, done that, than psychoeducational material or research. Narratives that resonate with your own experiences help you feel less alone and they teach you that there is possibly a way out.

Geneen's narratives brought hope into my life. Perhaps my experience will open up a doorway for someone else.

Always in the back of my mind is there the goal to keep the spotlight on food. After all, I began this process because I wanted to change my relationship with food. And that, I have learned, is going to require more work and more practice. I am going to have to be willing to pay attention to this relationship. I have found a free mindful eating program online. I downloaded it months ago. It sits and waits for me to be ready. I feel confident that freedom from food lies somewhere in the realm of mindfulness. I just have to find exactly what that answer is. My journey is not over.

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